What Did the Health Care Reform Act Actually Do?

On March 21, 2010, Congress completed its passage of major reform to the country's health care system, when the House voted for final approval of the legislation. The President signed the bill into law on March 23. The coverage of this legislation has been confusing, so the following summary is offered to clarify what the effects of this legislation are. This information is drawn from a variety of news sources and government reports.

General Effects

About 32.5 million people will gain health care coverage from this legislation. Of the newly covered people, about half (16 million) will be added to the Medicaid rolls. The remainder would be covered through subsidized private insurance for low income families. By 2014, all states will have insurance exchanges where individuals, families and small businesses can buy coverage. However, an estimated 23 million people are expected to remain uninsured as late as 2019. About one-third of the remaining uninsured would be illegal immigrants.

The cost of this increase in health care coverage is expected to be offset by cuts in Medicare spending, which start in the next few months, a tax on high-cost employer-sponsored health plans, which takes effect in 2018, and a tax on the investment income of the most affluent Americans. Although the increases will result in about a two percent growth in the share that health care costs contribute to the national economy (from 17.3% of the national economy in 2009 to 19.6% in 2019), the impact will also be to reduce the federal deficit by $143 billion in the next 10 years as a result of cost-shifting and increased taxes.

There will also be a change in how tax deductions are allowed for health care costs. Currently, deductions for unreimbursed health care costs are allowed when they exceed 7.5 percent of adjusted gross income. This deduction threshold will be increased to 10 percent in 2013 but the increase will be waived for individuals age 65 and older for tax years 2013 through 2016.

Most elements of the bill will be implemented between 2010 and 2014. Specific changes and when they will occur are described below. This is not an exhaustive list, because the bill is so complex. Therefore, references are available at the end of this document for more information.

Immediate Changes (2010)

- **Preventive health services.** All new health plans in either the group or individual markets must provide first dollar coverage for preventive services.
- **Coverage for those uninsured because of preexisting conditions.** Adults who have been denied coverage because of preexisting conditions will be able to sign on to a federally subsidized insurance program. Coverage in this stopgap insurance program isn't expected to be comprehensive and will expire once new insurance exchanges start operating in 2014.
- **Insurance companies cannot drop customers or raise rates prohibitively.** Insurance companies will not be allowed to drop people from coverage when they get sick, nor can they make health plans vastly more expensive for people with preexisting conditions. Lifetime limits on the amount of health care an insurer will cover will be eliminated, and use of annual limits will be restricted.
- **Insurance companies accountable for rates**. Creates a grant program to support states in requiring health insurance companies to submit justification for unreasonable premium

increases starting in plan year 2010. Insurance companies with excessive or unjustified premium increases between 2010 and 2014 could be prohibited from participating in the new Health Insurance Exchanges.

- **Coverage for children.** Companies won't be able to drop children under the age of 19 from coverage because of pre-existing conditions. Parents can also keep their children on a family plan till they turn 26 or get a job that offers them benefits.
- **Rebates for the Part D "donut hole".** An estimated 4 million Medicare beneficiaries who hit the so called "donut hole" in the program's drug plan (the gap in coverage which currently begins after $2,700 is spent on drugs) will get a $250 rebate in 2010. The cost of drugs in the coverage gap will then drop 50 percent in 2011, and the hole will be closed entirely by 2020.
- **Tax credits for small businesses.** For small businesses with fewer than 25 employ-ees and average wages of less than $50,000, the government will provide a tax credit of up to 35 percent of the cost of healthcare premiums. This will help these businesses provide coverage to their employees.
- **Reduced cost to cover early retirees.** A new temporary reinsurance program will be established to help offset the costs of expensive claims for employers and retirees for health benefits for retirees age 55 to 64.
- **Improves consumer assistance.** Provides aid to states to establish offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals. Also requires the Secretary of HHS to establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State. Additionally, any new health plan in the group or individual markets must implement an effective internal and external appeals process for coverage determinations and claims.
- **Reduces health care fraud.** Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.
- **Improves public health prevention efforts.** Creates an interagency council to promote healthy policies at the federal level and establishes a prevention and public health investment fund to provide an expanded and sustained national investment in prevention and public health programs.
- **Strengthens the quality infrastructure.** Additional resources are provided to HHS to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid and CHIP quality improvement programs. Also establishes a private, non-profit institute to identify national priorities and provide for research to compare the effectiveness of health treatments and strategies. Further, establishes an independent National Commission to provide comprehensive, nonbiased information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs.
- **Extends payment protections for rural providers.** Extends Medicare payment protections for small rural hospitals, including hospital outpatient services, lab services, and facilities that have a low-volume of Medicare patients, but play an important role in their communities.
- **Medicaid flexibility for states.** A new option will take effect, allowing states to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL) and receive current law Federal Medical Assistance Percentage (FMAP) .
- **Non-profit hospitals.** Establishes new requirements applicable to nonprofit hospitals beginning in 2010, including periodic community needs assessments.

- **Expands adoption assistance and credit.** Increases the adoption tax credit and adoption assistance exclusion by $1,000, makes the credit refundable, and extends the credit through 2011. The enhancements are effective for tax years beginning after December 31, 2009.
- **Support for investment in new therapies.** A two-year temporary tax credit for qualifying investments made in 2009 and 2010, subject to an overall cap of $1 billion, will be available to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.
- **Tax relief for health professionals with state loan repayment. F**or amounts received by an individual in taxable years beginning after December 31, 2008, gross income payments made under any State loan repayment or loan forgiveness program will be excluded to provide for the increased availability of health care services in underserved or health professional shortage areas.
- **Tax benefits for tribal Indian health care.** Excludes from gross income the value of specified Indian tribal health benefits. The provision is effective for benefits and coverage provided after the date of enactment.
- **Strengthens the health care workforce.** Expands and improves low-interest student loan programs, scholarships, and loan repayments for health students and professionals to increase and enhance the capacity of the workforce to meet patients' health care needs.
- **Special Deduction for Blue Cross Blue Shield (BCBS).** Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under Internal Revenue Code (IRC) Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.
- **Taxes**. Imposes a ten percent tax on amounts paid for indoor tanning services in lieu of the tax on cosmetic surgery. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning

Short-Term Changes (2011-2014)

- **Changes Medicare.** Medicare beneficiaries will get a free annual wellness visit, and the new health plans will be required to cover preventive services with little or no cost to patients. Medicare will also provide 10 percent bonus payments to primary care physicians and general surgeons. Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries. Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition and continues to reduce Medicare Advantage benchmarks in subsequent years relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Changes are phased-in over 3, 5 or 7 years, depending on the level of payment reductions.
- **Additional Medicaid savings.** A new Medicaid plan for the poor will allow states to provide more home- and community-based care for disabled people who would otherwise require institutional help. In 2013, Medicaid payment rates to primary care physicians for furnishing primary care services must be no less than 100% of Medicare payment rates in 2013 and 2014. Provides 100% federal funding for the incremental costs to States of meeting this requirement.
- **Limit on Flexible Spending Accounts**. Starting in 2013, flexible spending accounts used for health care costs would be subject to a $2,500 limit, and over-the-counter drugs would no longer be reimbursed without a prescription. Currently, there is no legal limit, but most employers set a cap around $4,000 or $5,000.

- **Reduces cost of health care coverage.** Health insurers, including grandfathered plans, must annually report on the share of premium dollars spent on medical care as opposed to profits or administration and provide consumer rebates where less than 80 to 85 percent of dollars are used for benefits. In 2012, physician payment reforms, hospital value-based purchasing and hospital readmission tracking will be implemented. A new Center for Medicare & Medicaid Innovation will be established to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals. Creates incentives for State Medicaid programs to cover evidence-based preventive services with no cost-sharing, and requires coverage of tobacco cessation services for pregnant women. In 2013, electronic exchange of health information to reduce paperwork and administrative burdens and costs will be mandated.
- **Strengthens coordination of care.** Establishes a national pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care. In 2013, a national pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care will be implemented.
- **Strengthens community health centers and the primary care workforce.** Provides funds to build new and expand existing community health centers, and expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas. Establishes a Graduate Medical Education policy allowing unused training slots to be re-distributed for purposes of increasing primary care training at other sites.
- **Cafeteria Plan changes.** Creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This would ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from nondiscrimination requirements applicable to highly compensated and key employees.
- **Expands primary care, nursing, and public health workforce.** Increases access to primary care by adjusting the Medicare Graduate Medical Education program. Primary care and nurse training programs are also expanded to increase the size of the primary care and nursing workforce. Ensures that public health challenges are adequately addressed.
- **Standardizes the Definition of Qualified Medical Expenses.** Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the itemized deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.
- **Increased Tax for Withdrawals from Health Savings Accounts and Archer Medical Savings Account Funds for Non-Qualified Medical Expenses.** Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 to 20 percent.
- **Pharmaceutical Manufacturers Fee.** Imposes an annual, non-deductible fee on the pharmaceutical manufacturing industry allocated according to market share and not applying to companies with sales of branded pharmaceuticals of $5 million or less.
- **Taxes**. In 2013, a 2.3 % excise tax on the sale of a medical device by a manufacturer or importer will be implemented, with exemptions for eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use.
- **Limits Executive Compensation.** Limits the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross

premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements with respect to services performed after 2009.

Long-Term Changes (2014 onwards)

- **Requires insurance.** Beginning in 2014, all Americans would be expected to get insurance or face penalties. The fine depends on household income, but there's also an upper limit; a family would pay a maximum of $2,085. Extremely low-income people will be exempt from the fines.
- **Eliminates Annual Limits**. Prohibits all employer plans and new plans in the individual market from imposing annual limits on the amount of coverage an individual may receive.
- **Ensures Coverage for Individuals Participating in Clinical Trials.** Prohibits new health plans from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.
- **Large employers must provide insurance**. Large employers are expected to provide coverage to workers or face fines. Businesses with 50 or more workers who do not provide coverage will be fined $2,000 for each uninsured employee.
- **Medicaid expanded for low-income families.** Medicaid, the state-federal program for the poor and disabled, will be expanded sharply starting in 2014, when it will offer care to people with annual incomes less than 133 percent of the federal poverty level ($29,326 for a family of four).
- **Tax credits for low-income families.** People with incomes up to 400 percent of the federal poverty level will receive tax credits on a sliding scale for their health care premiums.
- **State health insurance exchanges.** State-based insurance marketplaces called exchanges are expected to go into effect in 2014. The exchanges will offer opportunities for people to pick and choose the plan that works best for them. Once the exchanges are up and running, insurers will be barred from rejecting applicants based on their health status. The new policies sold on the exchanges will be required to cover not just hospitalizations, doctor visits, and prescription medicines, but also maternity care and certain preventive exams. A choice of coverage through a multi-State plan, available from nationwide health plans under the supervision of the Office of Personnel Management, would also be available.
- **Excise tax on high cost employer-provided health plans. In 2018, a t**ax is on the cost of coverage in excess of $27,500 (family coverage) and $10,200 (single coverage), increased to $30,950 (family) and $11,850 (single) for retirees and employees in high risk professions will be implemented. The dollar thresholds are indexed with inflation, and employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

Other sources of information:

http://healthreform.kff.org/timeline.aspx, Henry J. Kaiser Family Foundation

http://docs.house.gov/energycommerce/TIMELINE.pdf, Committees on Ways & Means, Energy & Commerce, and Education & Labor, 4/2/10